

SIDE-BY-SIDE COMPARISON OF MENTAL HEALTH PROVISIONS IN HEALTH CARE REFORM

	Senate	House
Insurance Market Reforms	<p>Requires mental health and substance use disorder services as part of the minimum benefits package (exempts large employers).</p> <p>Requires individual, small group and large group plans to comply with the 2008 parity law</p> <p>Young adults permitted to remain on their parents' health insurance until age 26</p>	<p>Requires mental health and substance use disorder services as part of the minimum benefit package.</p> <p>Requires all plans, including plans in the exchange (which includes the public plan), individual, small and large groups to comply with the 2008 parity law.</p> <p>Young adults permitted to remain on their parents' health insurance through age 26.</p>
Health Insurance Exchanges	<p>Requires the Department of Health & Human Services (HHS) to award grants (available until 2015) to States to establish American Health Benefit Exchanges by 2014.</p> <p>Requires HHS to set standards for the Exchanges and qualified health plans.</p> <p>Allows any individual who is lawfully residing within a State and who isn't incarcerated and small employers to participate in a State's Exchange. Beginning in 2017, large employers may participate as well.</p> <p>Allows individuals to apply for and enroll in Medicaid, Children's Health Insurance Program (CHIP), or the exchange through a state-run website.</p> <p>Defines the services that must be offered by all plans</p>	<p>Establishes the Health Insurance Exchange which facilitates offering of health insurance choices, including a public plan option.</p> <p>Beginning in 2013, individuals without insurance and small employers are allowed to participate in the Exchange. In 2014, employers with 50 or fewer employees can participate and in 2015, employers with 100 and fewer employees may participate with the ultimate goal of eventually allowing all employers to participate. **The exchange does not include Medicaid.</p> <p>Requires the Health Choices Commissioner (who oversees the Exchange) to conduct outreach and enrollment activities to ensure timely enrollment, including outreach to individuals with mental illness or cognitive impairments.</p> <p>Defines the services that must be offered by all plans</p>

	<p>within the Exchange. Includes rehabilitative and habilitative services; mental health and substance use disorder services, including behavioral health treatments.</p> <p>Allows states to require benefits in addition to the essential health benefits.</p>	<p>within the Exchange. Includes rehabilitative and habilitative services; mental health and substance use disorder services, including behavioral health treatments. Requires that the Secretary of HHS consider adding domestic violence counseling to behavioral health or primary care visits.</p>
Medicaid	<p>Expands eligibility to all adults at or below 133% of poverty (\$30,000 a year for a family of 4). Newly-eligible adults would be enrolled in a “benchmark” plan that would include addiction and mental health treatment services at parity.</p> <p>Establishes an optional Medicaid benefit through which states could offer community-based attendant services and supports to Medicaid beneficiaries who would otherwise require the level of care offered in a hospital, nursing facility, or intermediate care facility for the mentally retarded.</p> <p>Removes barriers to providing home- and community-based services (HCBS) by giving states the option to provide more types of HCBS through a state plan amendment, rather than through a waiver, to individuals with higher levels of need. Extends full Medicaid benefits to individuals receiving HCBS under a state plan amendment.</p> <p>Provides states the option of enrolling Medicaid beneficiaries with chronic conditions, including serious and persistent mental illness, into a health home. Grants of up to \$25 million are provided for planning and implementing the pilot projects.</p> <p>Allows all young adults below age 25 who were formerly in foster care to be eligible for Medicaid and</p>	<p>Expands eligibility to all adults at or below 150% of poverty (\$33,800 a year for a family of 4). Newly-eligible adults would be provided addiction and mental health services, at a state’s option, according to the state plan.</p> <p>Clarifies that federal Medicaid law does not prohibit State Medicaid programs from covering therapeutic foster care for children in out-of-home placements.</p> <p>Establishes a 5-year pilot program to test the medical home concept with Medicaid beneficiaries. Specifically names the inclusion of medically fragile children and high-risk pregnant women. The federal government would match the costs of community care workers at 90% for the first 2 years and 75% for the next 3 years. The total funding provided for this project is \$1.235B.</p> <p>Requires States to suspend, not terminate, eligibility for beneficiaries under age 19 who are incarcerated in a public institution during the period of incarceration.</p>

	all its benefits, including Early and Periodic Screening, Diagnosis, and Treatment.	
CHIP	Requires states to maintain current eligibility levels for CHIP through Sept. 2019. From 2014 to 2019, states will receive a 23 percentage point increase in the CHIP match rate. There is no provision to reauthorize CHIP after 2019.	Prohibits states from adopting eligibility standards, methodologies, or procedures in their CHIP programs that are more restrictive than those in effect as of June 16, 2009. This maintenance of eligibility ends upon expiration of the CHIP program on Dec. 31, 2013.
Health Disparities	<p>Language Access: Plans in the state exchanges must submit information in plain language. Plain language is defined as “language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing.</p> <p>Workforce: Alters the Public Health Service Act (PHSA) by inserting the goals of dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training. The bill creates grants for programs that aim to meet these goals.</p> <p>Data Collection: Amends the PHSA by adding “Title XXXI – Data Collection, Analysis, and Quality.” Title XXXI states that HHS shall ensure any federally conducted or supported healthcare program, activity, or survey collects and reports: data on race, ethnicity, sex, primary language, and disability status; and data on the smallest geographic level if it can be aggregate. The Title also addresses healthcare disparities in Medicaid and CHIP by standardizing collection requirements. HHS shall evaluate approaches for the data collection to ensure it allows for the ongoing,</p>	<p>Language Access: Requires HHS to contract not later than 3 years after enactment with the Institute of Medicine to conduct a study that examines the impact on the quality of care, access to care, the reduction in medical errors and costs or savings associated with the provision of language access services to limited English proficient populations.</p> <p>Workforce: HHS will award grants to facilitate the development of cultural competency programs.</p> <p>Data Collection: The Health Commissioner of the Health Insurance Exchange is required to promote accountability of qualified health plans by conducting audits. The Commissioner shall collect data for the purposes of promoting quality and value, protecting customers, and addressing disparities in health and healthcare.</p> <p>Office of Minority Health: Transfers the OMH to the Office of the Secretary of HHS. Creates additional minority health offices in the following agencies: Centers for Disease Control, Substance Abuse and Mental Health Services Administration, Agency for Healthcare Research and Quality, Health Resources and Services Administration, and the Food and Drug Administration.</p>

	<p>accurate, and timely collection and evaluation of data on disparities in healthcare services and performance.</p> <p>Office of Minority Health: Transfers OMH to the Office of the Secretary of HHS. It shall award grants, contracts, enter into memoranda of understanding, cooperative, interagency, intra-agency and other agreements with public and nonprofit private entities and organizations that are indigenous human resource providers in communities of color to assure improved health status of racial and ethnic minorities, and shall develop measures to evaluate the effectiveness of activities aimed at reducing health disparities and supporting the local community. The bill also redesignates the National Center on Minority Health and Health Disparities, as the National Institute on Minority Health and Health Disparities, and the Institute will have expanded research endowments.</p>	
<p>Workforce</p>	<p>Includes a loan repayment program for individuals practicing pediatrics, child and adolescent MH/SUD services</p> <p>Authorizes grants to higher education institutions for MH/SUD professionals</p> <ul style="list-style-type: none"> • Priority will be given to institutions in which the training focuses on the needs of vulnerable groups, including individuals with MH & SUD and where applicants have demonstrated familiarity with evidence-based methods in child and adolescent mental health services including SUD prevention & treatment • \$8M is authorized for social work • \$12M for graduate psychology 	<p>Authorizes workforce development grants for providers of MH/SUD services; authorizes \$60 million for the program. Includes report language specifying addiction physicians.</p>

	<ul style="list-style-type: none"> • \$10M for professional child and adolescent MH/SUD • \$5M for training in paraprofessional child and adolescent work at state-licensed not-for-profit and for-profit organizations 	
Wellness & Prevention	<p>Substance use disorders are listed as a national priority in the report to be provided to Congress and the President by 7/1/10 by the National Prevention, Health Promotion and Public Health Council</p> <p>Requires SUD/MH services be provided at school-based community health centers</p> <p>Permits state or local health departments receiving grant funds through a Department of Health and Human Services (HHS) public health grant program, administered through the Centers for Disease Control and Prevention, to enter into contracts with MH/SUD providers and screening activities may include MH/SUD</p>	<p>Authorizes \$30M for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant program</p> <p>Provides for community prevention and wellness services grants to assist state or local health departments or public or private nonprofit entities in providing evidence-based community based prevention and wellness services. A “Health Empowerment Zone” community partnership addressing health disparities would also be eligible. At least 50% of these funds must be spent on implementing services whose primary purpose is to reduce health disparities.</p>

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